City and County of San Francisco

Department of Public Health

Raymond J. Baxter, Ph.D.
Director

RELEASE

To: Honorable Arthur Jackson, President
Health Commissioners

From: Raymond J. Baxter, Ph.D.
Director of Public Health

Re: Response to the Mayor's Office request for additional reductions-- 1993-94 budget

Date: April 5, 1993

This responds to the Mayor's Office request for additional reductions to our 1993-94 budget proposal. In our first 1993-94 budget proposal to you, we presented a budget pursuant to the Mayor's Office instructions that did not increase our General Fund allocation, despite significant anticipated cost increases. In order to do this, we proposed $32 million in revenue increases, administrative and operating cost reductions, and service cuts. As in our proposals to you over the last two years, we tried to minimize service cuts by raising revenues and cutting administration as much as possible. However, as a result of our aggressive efforts in previous years to increase revenues and cut administration, we had fewer opportunities to do this and had to present you with a proposal that included about $9 million in painful service cuts, mainly in mental health and substance abuse.

We now find ourselves in an extraordinarily difficult situation. The Mayor's Office has asked us to present a"worst case" scenario for an additional $25 million in cuts. This would amount to a total of $57 million in general fund cuts for next year. Had we not covered our anticipated cost increases, the DPH would need $182.4 million in 1993-94 general fund contribution to provide the same services we provide today. A $57 million cut represents 31 percent of that amount.

We are unable to propose any further revenue increases or administrative or operating cost reductions. We believe that it will be a significant challenge to achieve the ones we have recommended so far this year, especially considering the cuts we have made over the past two years. Attachment 1 details these changes. Since 1991-92, we have raised $83.6 million in new revenues, implemented $38.8 million in administrative and operating cost reductions, and cut $18.8 million from our services. These changes have required an extraordinary effort on the part of our employees and contractors, who are working in an increasingly difficult environment.

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Furthermore, these additional cuts would come at a time when the State is mandating radical changes to the health care delivery system in San Francisco by requiring us to implement managed care. We must not only take a leadership role to help design this new city-wide system, but also completely re-tool our own delivery system. This will require major operating changes and some strategic investments, not cuts.

As a result of this, we cannot approach these cuts the way we have in the past. Instead, we have chosen to lay out four different scenarios. These scenarios are as follows:

I. Defer salary increases for civil service employees and cost-of-living increases for contractors. Our costs are growing primarily due to salary standardization and contractor COLAs. Approximately two-thirds of the estimated additional costs of providing 1992-93 service levels in 1993-94 are due to salary standardization and contractor COLAs. Although we theoretically have a choice whether or not to grant COLAs to our contractors, we have chosen to do so in the past because of the disparity in what they are paid to do virtually the same work as our civil service programs. We believe not granting these increases is the most logical solution because of the alternative: devastating service cuts to our client population. By eliminating salary increases and COLAs in 1993-94, we could save $23 million.

II. Cut according to the Mayor's instructions, but try to preserve services to our most vulnerable populations. These cuts involve a major downsizing of our entire health care service system and large administrative and service reductions, including major inpatient cuts at San Francisco General Hospital and Laguna Honda Hospital. We attempt to meet our legal mandates and to preserve basic public health services and some services to the severely mentally ill, the homeless, and substance abusers. However, this proposal would sharply restrict our ability to participate in a managed care system--we would close 5 of 9 primary care clinics and reduce our outpatient capacity at SFGH by about one-third. The failure to compete in managed care would in turn threaten up to $120 million in DPH Medi-Cal revenues, which would also jeopardize our ability to provide other basic public health and mental health services.

III. Cut according to the Mayor's instructions, but preserve our ability to participate in a managed care system. Alternatively, we could preserve our ability to compete in managed care, but it would mean more devastating cuts to mental health and substance abuse services. In a managed care environment, the primary care clinics would be the backbone of our health care network, providing referrals to the rest of the system. Under this scenario, all of our health centers would remain open, but our mental health system would serve

about one-third of the clients it serves today, and substance abuse services would also be greatly reduced. This scenario also entails a major downsizing of our entire system, including proportional administrative cuts and major inpatient cuts at SFGH and LHH.

Both of these proposals are devastating to the system, and we can not stand comfortably behind either. We have investigated a number of alternatives, but given cuts of $57 million, these appear to be the only sort of options available to us. For example, we explored alternatives that would have cut SFGH dramatically, but because of the way Medi-Cal disproportionate share reimbursement works, these alternatives would have ended up actually costing the general fund money. We provide additional details about these scenarios in Attachments II and III.

IV. Restructure the financial relationship between the DPH and the City and County. The combination of the economic environment and the radical changes taking place in health care mandate changes in our working relationship with the City, if we are to survive. This alternative does not save the City $25 million in 1993-94, but we believe it has the ability to make our operations much more efficient over time. We are asking that the City work with us to plan these changes over the next three years, and make specific changes in the next year that we believe could save as much as $5 million without any additional service reductions beyond those detailed earlier this year. We spell out our financial restructuring proposal in detail in Attachment IV.

In summary, we believe that if we must cut an additional $25 million from our budget, the only acceptable way is to freeze salaries and COLAs. We also believe that we must change our financial relationship with the City if we are to survive in this highly competitive health care market and continue to provide services to the most needy populations.

ATTACHMENT ONE
SUMMARY OF DEPARTMENT OF PUBLIC HEALTH
BUDGET PROPOSALS 1991-92 TO 1993-94

Over the last two and a half years the State of California and the City and County of San Francisco have been faced with a declining economy resulting in unprecedented budget cuts. The City, including the DPH, has been forced to cover cost increases through a variety of revenue proposals, cost controls, and service reductions. As a result, the Health Department has been forced to reduce its reliance on the general fund at the same time it faced unavoidable cost increases and growing service demands. This documents summarizes some of the significant budget proposals developed and implemented by the Department of Public Health since 1991-92.

BUDGET PROPOSALS 1991-92	BUDGET PROPOSALS 1992-93	BUDGET PROPOSALS 1993-94	ADDITIONAL $25 MILLION TARGET
Maximizing Revenues: $83.6 million			
The DPH has been able to substantially increase revenues through a variety of new business plans, improved billing and eligibility practices, and by aggressively pursuing legislation to increase federal and state matching dollars. Revenue increases have also been achieved by having divisions work together closely to maximize every available revenue source and improve patient services. The DPH has successfully secured substantial grant revenues to enhance services, including family planning, substance abuse, and HIV related services. For example, in 1991-92 and 1992-93 the DPH received $33.8 million in Ryan White CARE funds and we anticipate another $28.3 million for 1993-94. As a result, by 1993-94 will anticipate adding $62.1 million in new HIV related services, none of which is dependent on the general fund.			
$19.2 million	**$52.1 million**	**$12.3 million proposed**	**None**
• Increase Medi-cal, Medicare and other payments at LHH $2.8 million, SFGH $4.1 million, DMSF $1.2 million • Improve charge capture at SFGH $8.2 million	• SFGH revenue: SB855 revenue, $28 million., Business Plans, $4.8million, other revenues, $9 million. • LHH revenue: SNF rate increase, $10.5 million. • Primary Care revenues: $500,000	• SFGH: business plans, rate hikes, and decreasing decertified days, $7.0 million. • LHH improved ancillary charges, $1.3 million and acute rehab charges, $500k. • DMSF rehab. rate, $700,000. • CHS SB910, $1.5 million, BEH fee increase, $300,000.	

Administrative Cuts and Management Efficiencies: $38.8 million

DPH has reviewed its organizational structure to cut administration, streamline operations and achieve significant cost savings over the last two and a half years. The proposed 1993-94 budget includes 5,878 positions (prior to an additional $25 million cut) down from 6,047 in 1990-91. Between 1989 and 1992 the DPH reduced the number of senior administrative positions by 23 percent, to 131 employees (Affirmative Actions Status Report, 1992). In 1992-93 less than one percent of the DPH workforce are senior administrative positions earning over $85,000 annually. All licensed clinical directors in mental health, the director of the AIDS Office and the Director of Community Public Health Services also maintain active clinical practices.

$11.5 million	$15.8 million	$11.5 million proposed	$5 to $23 million proposed
Administrators Earning $75,000+			
• 2 Assistant Hospital Administrators, 3 Assistant Directors of Nursing (ADN), 4 Clinical Directors, 1 Branch Director, 1 Budget Director, Downgrade 1 Clinical Director	• 1 Associate Director, 1 Finance Director, 1 Assistant Hospital. Administrator, 3 Assistant. Directors of Clinical Services I, 1 Supervising Public Health Nurse, 1 ADN	• 1 Assistant Director of Nursing, 2 Assistant Directors of Clinical Services I, 1 Supervising Public Health Nurse, 0.5 Director of Public Health Nursing, 1 Director of Clinical Services	
Admin./Program Consolidations			
• Community mental health services targeted the consolidation of 12 programs into five sites • Consolidate 2 involuntary psychiatric services. • Consolidated the budget and planning functions in DPH.	• Consolidate AIDS and CPHS administration in Community Health Services. • Inpatient and outpatient administration at SFGH. • Mental administration, $700,000. Consolidation of adult community mental health programs.	• Consolidate grants management office with AIDS and CPHS. • Consolidated 23 AIDS medical service contracts • Consolidate adult community mental health civil service and contractor programs into four Clusters of care.	

8-14

BUDGET PROPOSALS 1991-92	BUDGET PROPOSALS 1992-93	BUDGET PROPOSALS 1993-94	ADDITIONAL $25 MILLION TARGET
Administrative Cuts and Management Efficiencies: $38.8 million			
$11.5 million	**$15.8 million**	**$11.5 million proposed**	**$5 to $23 million proposed**
Other Management Efficiencies • LHH: Operating expenses including phone, light, heat, materials and supplies, training, etc., $670,000 • SFGH: Purchasing Discount Program, $700,000, changes in Clinical Lab ordering practices, $430,000, other operating savings, $1 million. • DMSF: COLA's, $600,000.	• SFGH: Transfer 10 Hospital Eligibility Workers to DSS, $500k, Admin. cuts, $500k. • LHH & DMSF: Operating expenses including phone, heat, materials and supplies, training, etc., $2.8 million • CHS: Operating and MIS, $1 million. Automate the Health Centers and Contracts Unit.	• SFGH: Cut 12 positions in administration and 17 in finance, $1.4 million. Pharmacy savings through prime vendor and group purchasing, $1.5 million. • LHH: Staff and operating reductions of $1.1 million • DMSF: Bill contracts for fee-for-service, $400,000.	• Eliminating salary standardization and contractor COLA's could save $23 million in 1993-94. • Restructuring the financial relationship between the DPH and the City could save $5 million in 1993-94.
Productivity (skill/service mix) • All divisions were required to increase workload with fewer staff resources.	• All divisions were required to increase workload with fewer staff resources. • Eliminate IMD patch at Cordilleras, sell 10 Napa beds, $1 million, sell 20 Napa beds transfer clients to IMD's $780k., sell 8 Gero-Psych beds and buy 26 IMD beds, $319k.	• All divisions will be required to increase workload with fewer staff resources. • Nursing skill mix changes at SFGH, $300,000 savings • Nursing skill mix changes at LHH, $500,000 savings. • Nursing skill mix changes at Forensics, $300,000. • Contract Home Health Agency, $433k.	

BUDGET PROPOSALS 1991-92	BUDGET PROPOSALS 1992-93	BUDGET PROPOSALS 1993-94	ADDITIONAL $25 MILLION TARGET

Service Reductions: $18.8 million to $40.9 million

Over the last two and a half years the Health Department developed a set of budget principles and implemented budget cuts that minimized service reductions wherever possible. Even with the Department's aggressive revenue generation and administrative and operating reductions, $900,000 and $8.7 million in service reductions or delays were implemented in 1991-92 and 1992-93 respectively. Many of these service reductions were due to Proposition A early retirement of clinical staff. With a general fund reduction totaling $57 million for the 1993-94 fiscal year, the DPH has exhausted its current options to increase revenue and reduce administrative and operating costs. For 1993-94 the DPH proposes to cut $9.2 million in services in round one and an additional $23 million in round two. These proposed reductions do not include anticipated cuts in health by the State.

$900,000

- DMSF: $889,000 of outpatient mental health programs were reduced.
- CPHS: Seniors prevention program reduced.

$8.7 million

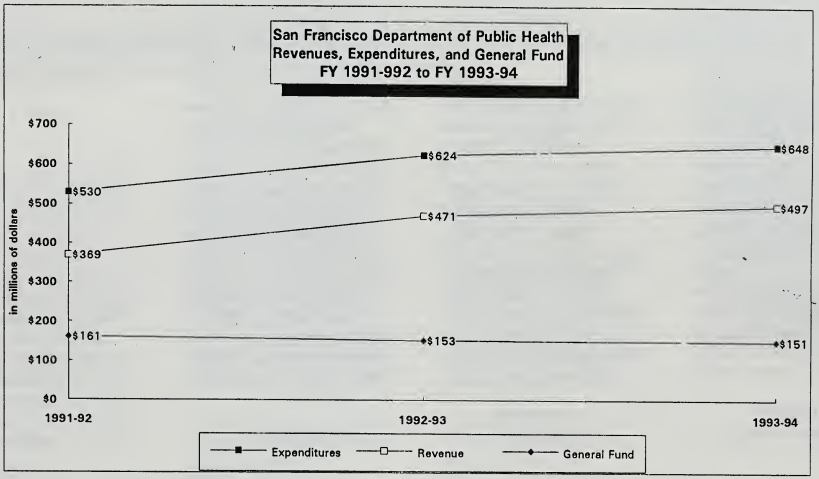
- CPHS: lost 12 Public Health Nurses, 7 Nurses, 4 Doctors, 1 Nurse Practitioner, 5 Social Workers, 5 Health Workers, 2 Physical Therapist and 1 Lab Tech. Delayed child lead program, mammography van and HIV primary care serv.
- Laguna Honda Hospital reduced admissions through September 1992, an average of 17 patient days per month.
- DMSF: Reduced nursing capacity at County Jail #7 and closed Sunset/Parkside, 29th Street and Team II Clinics.
- Increased diversion at SFGH and reduced inpatient census

$9.2 million proposed

- Cut $3.8 million in adult community mental health and 2 additional Napa beds
- Cut $1.9 million in substance abuse services including eliminating most methadone detoxification service, closing Harriet Street, Mission Council and Westside Tenderloin Detox Centers.
- Cut $1.7 million at SFGH including paramedics, reductions in medical clinic and nutrition services, and 15 ward beds.

$21 to $23 million proposed

- Both Scenarios: Reduce 80,000 outpatient visits at SFGH, cut 40 ward beds. Cut 350 patients from LHH and accept admits only from SFGH.
- Vulnerable Populations Scenario: Close 5 of 9 health centers and reduce mental health services by an additional $6.4 million.
- Managed Care Scenario: maintain the health centers but cut an additional $13 million from mental health.



The dollar amounts in this graph are derived from the DPH Program budgets submitted to the Mayor's Office. These dollar amounts are based on proposed revenues, expenditures and general fund, for 1992-93 and 1993-94.

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ATTACHMENT TWO

SCENARIO TWO: DOWNSIZE THE ENTIRE SYSTEM, BUT AS MUCH AS POSSIBLE PRESERVE SERVICES TO THE MOST VULNERABLE POPULATIONS

Total savings: $21 million

San Francisco General Hospital--$7.4 million savings
SFGH continues as the City's trauma center and maintains support of the paramedic division and the emergency room. This proposal would increase critical care and step down beds by 12 while reducing ward capacity by 54 beds. SFGH would maintain psychiatric census at 84, in order to maintain services to the most vulnerable in our system.

SFGH would reduce ambulatory care services by 82,000 visits, to 178,000. Specialty clinics will be maintained in order to support the trauma-related discharges and because the same provider staff for surgical services currently provide both inpatient and outpatient care. These services will also be available for consultation and referral for the community based clinics. For the most part, patients would have to seek primary care services outside of the DPH, with the exception of children, and those seeking perinatal and HIV services.

As part of this scenario, SFGH would eliminate all methadone services and reduce its support of the poison center to its fair share, from $600,000 to $300,000.

With these cuts, SFGH would save $7.4 million in 1993-94, and would eliminate approximately 225 FTE employees. Revenues would drop by $6.5 million. This proposal assumes that payor mix would stay the same and that SB 855 revenues would not be reduced. In order to do so, SFGH will have to carefully monitor unsponsored utilization, and wait times for services to unsponsored patients will greatly increase.

Laguna Honda Hospital--$1.8 million savings
Laguna Honda Hospital would limit its services to discharges from SFGH, and reduce its census by 300. To implement this change, it would close 300 beds, including all of Clarendon Hall. Admitting SFGH referrals at a rate of 40 per month coupled with approximately 70 general SNF discharges and deaths per month would take at least eight months to reach the target census of 800.

As part of this scenario, LHH would also close the Adult Day Health Center and the Senior Nutrition Program.

This scenario saves approximately $1.8 million general fund in 1993-94, $400,000 of which would come from eliminating the ADHC and Senior Nutrition programs. Revenues would drop by $18 million. It would also eliminate about 332 FTE employees.

Division of Mental Health, Substance Abuse and Forensics--$6.3 million savings
This scenario attempts to preserve services to the most vulnerable in our system. In doing so, the department attempted to reduce reliance on high cost institutional care, retain revenue producing functions, preserve services to children and geriatric clients, and retain conservatorship services, homeless services, supportive housing, vocational rehabilitation, case management, and residential care services. Forensics services are preserved at their current levels pursuant to the consent decree.

Mental health services would reduce 250 of 7500 outpatient/day treatment clients, eliminating 2 clinics; 30 of 200 state hospital clients; 40 of 700 skilled nursing clients; and 350 of 1200 residential treatment clients, eliminating 6 programs for a total savings of $5.1 million in 1993-94.

Substance abuse services would reduce 500 of 6400 outpatient and detox clients and 100 of 2000 residential treatment clients, for a total savings of $1 million.

The rape treatment center would reduce services to 200 of 550 clients, for a total savings of $200,000.

Community Health Services--$5.5 million savings
Under this scenario, the DPH would retain basic public health and environmental health services, but would dramatically reduce primary care services. The basic public health functions to be preserved include public health nursing, dental, health education, lab, maternal and child health, environmental health, or toxics services.

The largest single cut, saving $4.5 million, would be achieved by closing 5 of 9 health centers and reducing 44,000 primary health care visits. Services to children and HIV and perinatal services would be preserved. In addition, a number of contracts would be cut: over 1800 seniors would no longer receive medication education, 14,000 out of a total of 125,000 units of service to homeless and indigent clients would be reduced, 7,300 of 13,250 medical and social service visits to indigents would be reduced, and the DPH would reduce its capacity to do epidemiological oversight and surveillance. In CPHS, these cuts total $5.3 million.

In AIDS services, DPH would reduce some prevention services--follow-up on missed appointments and group training for health care providers. These cuts total $257,000.

ATTACHMENT THREE

SCENARIO THREE: DOWNSIZE THE ENTIRE SYSTEM, BUT AS MUCH AS POSSIBLE PRESERVE DPH ABILITY TO PARTICIPATE IN MANAGED CARE

Total savings: $22.7 million

San Francisco General Hospital--$7.4 million savings
At SFGH, this scenario is essentially the same as scenario two, except that 20 acute psych beds are closed as part of the much greater cut in DMSF.

SFGH continues as the City's trauma center and maintains the support of the paramedic division and the emergency room. This proposal would increase critical care and step down beds by 12 while reducing ward capacity overall by 54 beds. SFGH would reduce psychiatric census by 20 to 64 as a result of cuts in the mental health system.

SFGH would reduce ambulatory care services by 82,000 visits, to 178,000. Specialty clinics will be maintained in order to support the trauma-related discharges and because the same provider staff for surgical services currently provide both inpatient and outpatient care. These services will also be available for consultation and referral for the community based clinics. For the most part, patients would have to seek primary care services in the DPH community clinics. Pediatric and HIV services will be maintained.

As part of this scenario, SFGH would eliminate all methadone services and reduce its support of the poison center to its fair share, from $600,000 to $300,000.

SFGH would save $7.4 million in 1993-94, and would eliminate approximately 225 FTE employees. Revenues would drop by $6.5 million. This proposal assumes that payor mix would stay the same and that SB 855 revenues would not be reduced. In order to do so, SFGH will have to carefully monitor unsponsored utilization, and waits for service for unsponsored patients will greatly increase.

Laguna Honda Hospital--$1.8 million savings
This scenario remains the same as scenario two.

Laguna Honda Hospital would limit its services to discharges from SFGH, and reduce its census by 300. To implement this change, it would close 300 beds, including all of Clarendon Hall. Admitting SFGH referrals at a rate of 40 per month coupled with approximately 70 general SNF discharges and deaths per month would take at least eight months to reach the target census of 800.

As part of this scenario, LHH would also close the Adult Day Health Center and the Senior Nutrition Program.

This scenario saves approximately $1.8 million general fund in 1993-94, $400,000 of which would come from eliminating the ADHC and Senior Nutrition programs.

Revenues would drop by $18 million. It would also eliminate about 332 FTE employees.

Division of Mental Health, Substance Abuse and Forensics--$13 million savings
In order to preserve primary health care services, mental health and substance abuse services must be reduced much more dramatically than in scenario two. The department used most of the same principles in defining these cuts: reduce reliance on high cost institutional care, retain revenue producing functions, preserve services to children and geriatric clients, and retain as much as possible conservatorship services, homeless services, supportive housing services, vocational rehabilitation services, case management, and residential care services. Forensics services are preserved at their current levels pursuant to the consent decree.

Mental health services would reduce 500 of 7500 outpatient/day treatment clients, eliminating 3 clinics; 400 of 800 supportive housing clients, eliminating 5 programs; 40 of 200 state hospital clients; 200 of 1600 inpatient and emergency clients (including those served at SFGH inpatient); 90 of 700 skilled nursing clients; and 500 of 1200 residential treatment clients, eliminating 7 programs, for a total savings of $11.1 million in 1993-94.

Substance abuse services would reduce 1000 of 4000 homeless clients, closing one drop-in program; 790 of 6400 outpatient and detox clients, eliminating 3 programs; and 100 of 2000 residential treatment clients, closing one program for a total savings of $1.5 million.

The rape treatment center would reduce services to 300 of 550 clients, for a total savings of $400,000.

Community Health Services--$500,000 savings
Under this scenario, the DPH would retain basic public health and environmental health services, and would maintain basic primary care services in order to participate in managed care. Some contract services would be reduced in order to help meet the overall target. The basic public health functions to be preserved include public health nursing, dental, health education, lab, maternal and child health, environmental health, and toxics services.

The specific contract cuts include: over 1800 seniors will no longer receive medication education, 14,000 out of a total of 125,000 units of service to homeless and indigent clients would be reduced, 7,300 of 13,250 medical and social service visits to indigents would be reduced, and the DPH would reduce its capacity to do epidemiological oversight and surveillance. In CPHS, these cuts total $330,000.

In AIDS services, DPH would reduce some prevention services--follow-up on missed appointments and group training for health care providers. These cuts total $120,000.

THE CITY AND COUNTY OF SAN FRANCISCO AND THE DEPARTMENT OF PUBLIC HEALTH

FINANCIAL RELATIONSHIP: AN AGENDA FOR CHANGE

APRIL, 1993

PREPARED BY:
SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

RAYMOND J. BAXTER, PH.D.
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The City and County of San Francisco and the Department of Public Health's Financial Relationship: An Agenda for Change

Table of Contents

Introduction: Why is the DPH-City Financial Relationship Important? 3

How is DPH Financed? 5

What Does the City General Fund Buy? 6

How is the City's Payment to DPH Determined? 7

What Problems are Caused by the City's Current Financial Relationship to DPH? 8

Why Must the City-DPH Financial Relationship Be Changed Now? 10

How Might a Restructured Financial Relationship Between DPH and the City Work? 12

What Could we Accomplish the First Year? 14

What are the Potential Risks of a Restructured Financial Relationship? 15

How Can the Risks to DPH and the City be Controlled ? 16

Can DPH Manage Successfully Under a Restructured Relationship with the City? 17

INTRODUCTION:

WHY IS THE FINANCIAL RELATIONSHIP BETWEEN THE CITY AND COUNTY OF SAN FRANCISCO AND THE DEPARTMENT OF PUBLIC HEALTH IMPORTANT?

Over the next ten years, the DPH will face the most difficult challenges of its history. These include:

- Greater demands for service caused by the epidemics of AIDS, substance abuse, mental illness, homelessness and violence among its patient populations.
- The burgeoning growth in the segment of the population requiring long-term care.
- An increasingly competitive environment in San Francisco's health sector that is driven by the State's move towards managed care. This will require a complete overhaul of every aspect of the Department's operations in order to successfully serve our communities in the new system.
- National health care reform, which will reinforce this competitive environment through "managed competition"; and
- Cuts in health care spending, driven by federal, state and local deficits, which will in turn force the DPH to operate more efficiently if it is to survive.

Unaddressed, these challenges threaten the DPH's mission -- to promote and sustain the best possible state of physical and mental health and functioning for all San Francisco.

The DPH is not alone in facing challenge. Over the next several years, the State of California and its local governments will face the most difficult fiscal challenges of the era: large budget deficits juxtaposed with increasing urgent human and infrastructure needs. Never before has more needed to be done with less.

Restructuring the DPH's financial relationship with the City offers the potential to allow the DPH to be managed more effectively and efficiently -- to do more with less. By creating incentives for good management and revenue enhancement that have never before existed, the DPH can better use its current resources, while creating an important pool of new resources.

Combined, these will allow the DPH to meet its challenges while simultaneously controlling costs and City general fund in the long run. Financial restructuring has the opportunity to create a greater degree of accountability in DPH's use of public resources

by moving the relationship to a focus on payment for services rendered, rather than on management of line items in budgets.

The potential in changing the City and DPH's financial relationship has been recognized by the Mayor's Fiscal Advisory Committee (MFAC), the Controller's Office, and Peat Marwick. MFAC recommended expanding the use of the "enterprise" concept at San Francisco General Hospital (SFGH), by allowing it to keep and reinvest a portion of new revenues. The Controller's Office made an almost identical recommendation in its audit of SFGH. Given the growing integration of DPH's services, we are convinced that this concept needs to be extended to the entire Department.

The DPH faces increasing threats to achieving its mission, and San Francisco and the State face increasing threats to their fiscal viability. In light of this, the DPH cannot afford to do business as it has in the past. We must change to meet the demands of managed care and increasing deficits. Financial restructuring will have to be an integral part of that change.

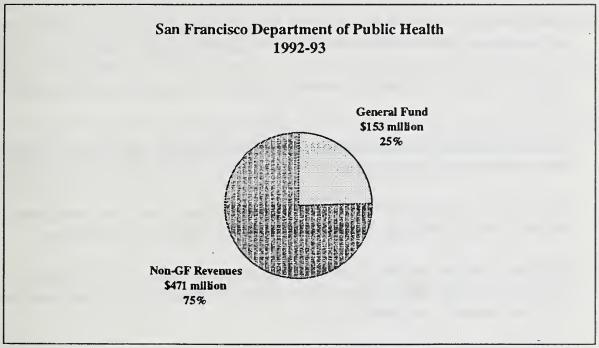
In this proposal, we seek the City's commitment to make the necessary reforms over the next three years to improve the DPH's financial relationship with the City -- to increase incentives to manage more efficiently and effectively. We also seek short term changes in the relationship that will allow some savings in 1993-94.

How is the Department of Public Health Financed?

The DPH differs from most City agencies in that it generates most of its own funding from patient care revenues paid by insurance companies and third parties.

Revenues (including work orders) will cover approximately 75% of DPH's $623.6 million expenditures in 1992-93.

The balance, 25% or $153.4 million, is funded by City general fund.



WHAT DOES THE CITY GENERAL FUND BUY?

The City general fund pays for a variety of services required by the City or as part of DPH's mission. These include:

- Care of the uninsured.
- Health and mental health services to inmates of the City's jails.
- The cost of clinic and emergency room visits in excess of the Medi-Cal rate, which does not cover costs.
- Substance abuse treatment and prevention services needed in addition to what is funded through state subventions and Medi-Cal.
- Mental health treatment services needed to provide a continuum of care that is not covered through state realignment and Short-Doyle Medi-Cal revenues.
- Skilled nursing care to medically complex patients that costs more than the Medi-Cal rate.
- Basic Public Health services, including prevention education, public health nursing, and communicable disease control.
- HIV services, including prevention and education, primary care, case management, residential home health care, and a variety of support and advocacy services.
- Emergency medical services, including disaster preparedness, the EMS Agency, 911 dispatch, paramedic services to the unsponsored, base station, trauma services to the unsponsored, and poison control.
- A continuum of services to children.
- Compliance with federal and state regulations regarding hazardous waste, asbestos, occupational safety and health, and employee assistance.
- Environmental health and sanitation services relative to jail facilities, homeless hotels, and water quality.

How Is the City's Payment to DPH Determined?

Even though the general fund pays for a minority of DPH's total service volume and the general fund accounts for only 25% of DPH's expenditures, the City controls DPH's entire budget. Each year the DPH and the Mayor's Office negotiate separate revenue and expense targets for each Division of the DPH. The difference is funded by the general fund.

Revenues collected and expense savings achieved in excess of budget targets are usually deducted from the City general fund contribution for that year. Conversely, the City bears the financial liability should DPH overspend or under collect.

Special initiatives or program enhancements are requested by DPH or the City, and expense authority is granted on a line item basis by the Health Commission, the Mayor, and the Board of Supervisors. On the downside, if City expenditures or revenues do not meet budgeted targets, the DPH can then be required by the City to make additional mid-year cuts by imposing hiring freezes, furloughing employees, or holding off on other planned expenditures. These cuts may or may not have anything to do with DPH finances or performance.

This method of payment and budgeting differs radically from that used by other hospitals and private businesses, which base each year's expense budget on expected revenues. Hospitals also normally have an amount added to their budgets for depreciation that allows them to fund capital replacement.

WHAT PROBLEMS ARE CAUSED BY THE CITY'S CURRENT FINANCIAL RELATIONSHIP TO DPH?

The current financial relationship is not optimal for both DPH and the City in many ways.

- **Lack of Basic Information, Impaired Accountability**

  The current method of paying for general fund services provides little information to either party regarding the type, volume or cost of services purchased by the City or rendered by DPH. Accountability is difficult without such basic information.

- **Disincentives for Good Management**

  The current method of budgeting and controlling the budget removes any financial incentive for good financial or operational management. DPH managers cannot benefit from any surpluses generated above targets. Instead:

  - Revenues collected in excess of revenue targets, such as those resulting from increased reimbursement rates, rate appeals or eligibility initiatives, are typically returned to the City's general fund. There is no incentive to pursue creative revenue opportunities.

  - Savings achieved in excess of expense targets through various productivity gains likewise return to the City's general fund.

  Revenue enhancements and operational efficiencies are often difficult to achieve and require considerable resource investment, staff training and reorganization. There is little incentive to pursue these efforts in the absence of any resulting institutional gain. In fact, rather than commending departments for saving money, the City usually recommends cuts on a line item basis to department budgets if their level of spending is less than what was budgeted. Despite these disincentives, the DPH has markedly increased revenues and reduced operating costs. However, these have only served to offset general fund reductions or increases in citywide labor cuts.

- **Inability to Reallocate Surpluses/To Self-Fund**

  Because the DPH cannot retain or redirect excess revenues or expense savings into operational or programmatic improvements, it is unable to plan effectively to meet ongoing needs. It is also cut off from one of the single most important funding sources available to other hospitals and businesses: the ability to self-fund.

- **DPH Reliance on the City for New or Unforeseen Financial Needs**

  Without incentives to create surpluses or the ability to reallocate them, DPH is greatly dependent on the City for the funding of new programmatic, regulatory and operational expenses, although the DPH can seek grants for these requirements. However, the City is financially liable for under collection or overspending by DPH.

- **City Micro-management**

  In the absence of built-in incentives to control costs, the Mayor's Office and the Board's budget analyst resort to episodic, micro-managerial review of DPH's spending and staffing. The result is extremely staff-intensive for both parties and diverts attention from creative problem solving. The outcome is frequently detrimental to DPH program continuity and management, and adds to overhead costs for the City and DPH.

- **Limited Ability to Plan**

  Unlike other health care providers who plan several years in advance based upon anticipated resources, DPH cannot forecast general fund payments beyond a single year. These payments are not determined by the services purchased or delivered, and frequently not even by DPH's financial performance, but rather by unrelated citywide budget developments. In fact, planning even within a single year is difficult, because of the City's mid-year budget adjustments.

  There is also a great deal of discontinuity in decision-making over the course of a year. For example, funds are added in the beginning of a year for a service or investment, and then later in the year a decision is made not to do it. This greatly impedes managerial effectiveness.

WHY MUST THE CITY-DPH FINANCIAL RELATIONSHIP BE CHANGED NOW?

- **Unprecedented state and local budget deficits.** Over the past two years, both the State and the City and County of San Francisco have faced unprecedented budget deficits. These deficits, in turn, have forced unprecedented cuts in the Department of Public Health. In 91-92 and 92-93, the DPH cut a total of $107.3 million from its anticipated general fund contribution in response to Mayor's Office requests for cuts. Until now, the DPH has been able to do this mainly with new revenue initiatives and with cuts to its administration and its operating costs. However, now these deficits threaten basic services. Financial restructuring could improve DPH incentive and efficiencies and help significantly in mitigating these services losses.

- **Managed care.** The State has mandated a rapid implementation of managed care in the Medi-Cal program in an effort to control cost increases and to improve access to care. The State DHS is requiring San Francisco to be one of the first counties to move forward with this initiative over the next couple of years. Rather than being paid for each service provided, managed care will mean that the DPH will receive a set rate of payment per month for each person enrolled in the Medi-Cal program, regardless of the services required. This will require a complete change in the operations of the department. No longer will individuals be able to seek and choose services on their own, but the DPH will have to manage each client and carefully monitor all service utilization. This change will require the DPH to completely change its care delivery system and to make investments in financial and information systems. With few new resources in sight, DPH will have to become increasingly efficient to manage this change. Managed care promises some opportunities, but it also poses significant risks to the DPH and to the City.

- **National health care reform**. "Managed competition" will form the underpinning of the national health care reform. This structure should be fairly consistent with the way the State is moving forward with Medi-Cal managed care. Managed competition will probably increase these same opportunities and risks to San Francisco.

- **Demands for service are growing**. The same economic forces that are resulting in federal, state, and local deficits are also resulting in increased demands for service. As people lose their jobs, they also lose their health insurance and turn to the City for their care. They may also become homeless, and require additional health and social services. In addition, the City's senior population represents 20 percent of the City's total population and continues to grow. As the City's economic circumstances have eroded, violence has increased and resulted in major threats to the City's health.

- **DPH infrastructure is crumbling.** Without a reliable and adequate way of financing capital improvements and equipment, the DPH cannot maintain its operations. The current way of funding capital puts DPH in competition with other City agencies for a miniscule amount of funds--$5 to $10 million annually. DPH invests far less of its budget for these improvements than it should to maintain them, even in relation to other safety net institutions. For example, the ratio of capital to operating expenditures at private hospitals is 11%, at safety net hospitals is 5.3%, and last year at SFGH totalled 1.5%. SFGH is not as old as the average safety net hospital, but it will not survive as long with this rate of capital investment. For example, a recent seismic evaluation points to the need for at least $60 million to refurbish, retrofit, and restore parts of SFGH. In addition, the hospital is still trying to correct licensure problems from when it opened in 1973. Financial restructuring would enable the entire DPH to plan for and fund its capital and equipment needs more effectively, in relation to the other services it provided.

For example, if SFGH could issue bonds, it could take advantage of the Medi-Cal capital pass-through program, SB 1732. This would allow Medi-Cal to pay for a portion of capital financing through the Medi-Cal rate.

At Laguna Honda Hospital, the failure to act to replace the facility for so many years has left us with the current financial dilemma about replacing the entire structure at great cost to City taxpayers.

How Might a Restructured Financial Relationship Between DPH and the City Work?

The DPH proposes a restructured financial relationship with the City that will be negotiated and phased in over the next three years. We envision fundamental changes that will most likely involve changes to the City codes and to the Charter. We would like to work with the Mayor's Office, the Controller, the CAO, and the Board of Supervisors to develop these changes.

In essence, DPH proposes that the City purchase services from DPH at an agreed-upon price, and provide DPH the management flexibility necessary to provide services for that price. Such an arrangement should include the following:

- **Establish prices for City mandated services.**
  - These would be based upon existing third party methodologies wherever possible and equitable.
- **Establish an adequate method for funding capital expenses.**
  - Routine capital expenditures, including movable equipment, would be funded by a percentage add-on to prices.
  - The City would continue to finance major reconstruction through the sale of bonds, assuming favorable rates.
- **Provide DPH with the managerial flexibility necessary to operate efficiently.**
  - These changes would be developed in conjunction with appropriate city officials, and be included in the overall transition plan. These changes would allow for greater efficiency in the context of improved managerial autonomy.
- **Establish Billing and cash flow arrangements.**
  - The City would make periodic interim payments through the year to DPH to maintain cash flow. These would be reconciled at year's end to the City's actual payment liability.
  - DPH would provide billing information to the City for payment and audit purposes.

- **Establish a joint DPH-City reserve fund to protect both DPH and the City against unforeseen risks.**

  - This would provide the City information needed in its role as a payer for mandated services and financier of major capital projects.

  - Internal management reporting will be restructured to meet the evolving needs of DPH senior management.

- **Develop a transition plan.**

  - A transition plan would govern implementation of a restructured financial relationship between the City and DPH. The plan would be developed in conjunction with the Mayor's Office, the Controller, the CAO, and the Board of Supervisors.

- Each DPH Division will have an individual transition plan as part of the overall plan.

- **Benefits to DPH**

  - Greater ability to participate successfully in a managed care system.
  - Greater incentives to identify and address operating inefficiencies.
  - Greater incentives to develop and implement creative revenue-generating initiatives.
  - Greater flexibility in capital acquisition and financing.
  - Greater emphasis upon accountability at all levels with DPH; necessary framework for decentralization of responsibilities to managers.
  - Greater predictability, ability to plan.
  - Greater managerial flexibility.
  - Enhanced ability to operate effectively in a financial environment that is becoming increasingly competitive.
  - Better use of current resources; access to additional resources to meet new health care challenges (growth of AIDS, mental health, substance abuse demands, growth of the uninsured, homeless.

- **Benefits to the City**

  - Greater predictability of general fund payments to DPH.
  - Greater accountability in the use of City general fund monies based on better information on how and where they are spent.
  - Continued authority to determine the scope of services it is willing to purchase, and better information about the services provided.
  - Meaningful, comprehensive oversight of City funding to DPH without the need for episodic, micro-managerial spending reviews.
  - Reduction of DPH dependence on City general fund over time.

- Ability to meet new health care challenges, improve the DPH system while minimizing new general fund demands.

What Could We accomplish the First Year?

In 1993-94, we propose some first steps that we believe could help us save an additional $5 million or so in operating costs without program impact. These steps could include:

- No City-initiated requisition or equipment controls or freezes;
- CIAC approval for capital projects that treats DPH as an enterprise department;
- expedited EIPSC approval for MIS projects;
- flexibility in designating civil service classifications for those that are unique to the DPH;
- ability not to use DPW if we can purchase the services cheaper elsewhere;
- streamlining purchasing processes, including allowing prepayment contracts;
- allowing continuing appropriations;
- automatically allowing carry forwards;
- no mid-year budget adjustments or delays in approving supplementals or fund transfers;
- no restrictions on surplus transfers;
- ability to utilize indirect cost recoveries.

We understand the difficulty of implementing many of these measures in such difficult economic times. For example, we understand that the City must have some ability to reduce expenditures mid-year if city-wide revenues do not meet targets. However, we believe many of these measures are do-able even in that context, and would like the ability to implement them in the context of our budget negotiations for 93-94.

WHAT ARE THE POTENTIAL RISKS OF A RESTRUCTURED FINANCIAL RELATIONSHIP?

- **Potential Risks to DPH**

  - Difficulty in bringing DPH costs within prevailing third party prices.
  - Unpredictable costs which cannot be incorporated with the DPH-City pricing structure, such as the cost of addressing new epidemics or emergency conditions arising from natural disasters or civil disobedience.

- **Potential Risks to the City**

  Global Risks:

  - Unpredictable non-DPH expense demands, revenue shortfalls.
  - Increased city wide demand for DPH general fund services, such as increases in the medically indigent.
  - Increased city-wide demand for DPH consultation and oversight in environmental and toxics matters, particularly as the community becomes more knowledgable about such issues and regulations become more stringent.

  DPH-Specific Risks:

  - Difficulty in accurately pricing DPH services.
  - More limited control of DPH spending while bearing financial and political liability for potential DPH deficits.
  - Inability of DPH to accurately project service volumes.
  - Inability of DPH to accurately project rate changes.
  - Failures of DPH management, including inability to control expenditures and failure to maximize revenues.

The risks of a restructured financial relationship can be controlled, however, and need not impede implementation.

How Can the Risks to DPH and the City Be Controlled?

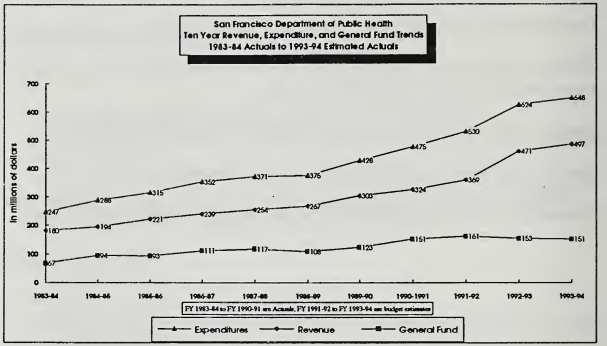
Risks to both DPH and the City can be controlled in a number of ways.

- Continued joint DPH-City involvement in periodic updating of the price setting mechanism to account for changes in the underlying volume and cost of general fund services.
- Continued joint DPH-City negotiation of major capital projects.
- Development of a joint DPH-City reserve fund for contingencies.
- Explicit agreement about respective performance failures which require reconsideration of the new financial arrangement.
- Development of enhanced management reporting and monitoring capability.
- Establishment of a clearly defined transition process and period.
- Oversight and control by the Health Commission which is appointed by the Mayor.

CAN DPH MANAGE SUCCESSFULLY UNDER A RESTRUCTURED FINANCIAL RELATIONSHIP WITH THE CITY?

DPH has demonstrated outstanding financial performance over the last decade, even in the absence of financial incentives.

- Between 1986 and 1993 revenues increased 103 %, from $239 million to $484 million.



- SFGH has been remarkably successful in generating additional revenues. This is attributable to implementation of financial information systems, self-funded contracts, business plans and other innovations that have more than offset the original investment.

- Sponsored legislation that added new opportunities to bill Medi-Cal for administrative case management. This initiative has already added $1.3 million to the budget through public health nursing, and has the opportunity to add much more.

- Began cost-reimbursed billing at two health centers by being designated as a Federally Qualified Health Center (FQHC)--are developing applications for additional designations. Initial estimates indicate that additional annual Medi-Cal revenues will range between $1-2 million.

- The city tax levy as a percent of total DPH expenditures has declined steadily from a high in 1986 of 32 % to 23 % in 1993.

Conclusion: DPH has amply demonstrated over time the financial discipline and capability necessary to manage under a restructured financial relationship with the City.

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